STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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F0000	This visit was for the Investigation of Complaint IN00112898. Complaint IN00112898 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F279, F309 and F441. Unrelated deficiencies are cited. Survey date: July 25, 26, and 30, 2012 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Survey team: Jennie Bartelt, RN Census bed type: SNF: 0 SNF/NF: 70 Total: 70 Census payor type: Medicare: 11 Medicaid: 56 Other: 3 Total: 70 Sample: 6 These deficiencies reflect state findings	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for survey ending July 30, 2012. Due to the low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allecgation of compliance. Thus, the facility respectfully requests the granting of paper compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2. Quality review completed on August 1, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified timely for possible treatment of rash with itching. (Resident B). The facility also failed to follow up on	F0157	**F-157 It is the practice of this provider to immediately inform resident, consult with the residents physcian, and if known, notify the residents legal representative or an**	08/29/2012

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	information faxed to the physician related to possible removal of a resident's urinary catheter (Resident F) The deficient practice affected 2 of 6 residents reviewed related to physician notification in a sample of 6. Findings include: 1. The clinical record for Resident B was reviewed on 7/25/12 at 1:15 p.m. The Weekly Skin Assessment, dated 7/9/12, indicated next to "Yes" for Discoloration/Rashes, "Rash to chest & R [right] [arrow pointing up - upper] arm." The Weekly Skin Assessment, dated 7/10/12, indicated a check mark "No" next to Discoloration/Rashes. The assessment was signed by the Director of Nursing. Nurses Notes, dated 7/15/12 at 1:15 p.m., indicated, "Resting abed - rashy area remains to [arrow pointing up - upper] rt [right arm] - scattered to rt shoulder - c/o [complains of] itching. [Symbol for no] other area noted." The Weekly Skin Assessment, dated 7/16/12, indicated next "Yes" for Discoloration/Rashes, "To [arrow pointing up] chest & [arrow pointing up]		**interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the residents physical, mental or psychosocial status a need to alter treatment significantly or a decision to transfer. What corrective action(s)ill be accomplished for those residents found to have been affected by the deficient practice?** Resident B's rash is resolved Resident F's foley catheter has been discontinued. **How other residents having the potential to e affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All resident's has the potential to be affected by the alleged deficient practice. · Licensed nurses were in-serviced on Change of condition/notification of Physician/family by the DNS/designee no later than 8/10/12. Post test included. · Non-compliance will result in further education including disciplinary action. · DNS/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the efficient practice does not recur?** · All licensed nurse	

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	R [right] arm. Nurses Notes, dated 7/16/12 at 11:00 p.m., indicated, "Pt abed up ad lib [as desired]. Rash rt arm remain c/o itch. [Symbol for no] [sic] c/o." Nurses Notes, dated 7/17/12 at 2:15 a.m., indicated, "Resting abed. Red rashy area remains to [arrow pointing up - upper] rt arm & chest. C/O itching." Nurses Notes, dated 7/17/12 at 11:00 p.m., indicated, "Resting abed up ad lib. Rash remains [arrow pointing up - upper] arm and chest. C/O itch area washed soap & H2O [water] pt states relief of itch @ this time." The Weekly Skin Assessment, dated 7/18/12, indicated next to "Yes" for Discoloration/Rashes, "Appears to be heat rash to BUE [bilateral upper extremities] & chest." A notation indicated, "This writer believes rash related to Res. [resident] wearing jacket out to smoke in hot temperatures." The assessment was signed by the Staff Development Coordinator. Nurse's Notes, dated 7/18/12 at 2:00 a.m., indicated, "Res abed watching TV....Rash remains to [arrow pointing up] R arm & chest. Cleansed area [symbol for with]		were in-serviced on change of condition/notifications of Physician/family by the DNS/designee no later than 8/10/12. Post test included. · Twenty-four hour report sheets, new orders and documentation will be reviewed daily by the DNS/designee to identify residents with a change in condition. · Residents identified will be further reviewed to ensure Physician/family notification was completed and timely. · Non-compliance will result in further education including disciplinary action. · DNS/designee responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The DNSand/or designee will complete Change of Condition weekly x 4 weeks, monthly x 6 months and quarterly thereafter for any resident identified from new orders, 24hour report sheets, and documentation reviewed. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	soap & H2O lotion applied for c/o itch." Documentation failed to indicate the physician was notified of the resident's rash (noted on 7/9/12), followed by rash with itching (noted on 7/15/12), until the Nurse Practitioner visited on 7/20/12. The Physician's Progress Notes, dated 7/20/12, indicated, "S [subjective]: Rash on chest & RUA [right upper arm] pruritic noticed by staff & pt. [patient] today. O [objective]: Confluent spotty pink dry papular rash A/P [assessment/plan] - Eczema -Betamethisone [sic] cream BID [twice daily]." The Physician Telephone Orders, dated 7/20/12, indicated, "Betamethasone cream 0.05% apply BID X 7d [seven days] dermatitis." The "At Risk for Impaired Skin Integrity Care Plan," originally dated 1/24/12, and most recently updated 6/26/12, indicated interventions including, but not limited to, "Assess and document skin condition weekly and as needed, notify MD of abnormal findings." During interview at the Exit Conference completed on 7/30/12 at 9:00 a.m., the Director of Nursing indicated she had			

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	reviewed the record, and the physician would not have been notified of the rash with itching, since it was managed by washing and lotion. 2. The clinical record for Resident F was reviewed on 7/25/12 at 1:50 p.m. Nurse's Notes for 6/26/12, beginning at 8:30 a.m., indicated the resident complained of abdominal pain and feeling of fullness, followed by a 10:30 a.m. note that indicated the resident complained of nausea and increased abdominal distention. An as needed antiemetic was administered, and a call was placed to the physician. At 12:30 p.m., the resident continued to complain of abdominal discomfort, and a second call was placed to the physician. Nurse's Note on 6/26/12 at 12:40 p.m., indicated, "N/O's [new orders] rec'd [received] et [and] noted to anchor 16 Fr [french] 5 cc F/C [Foley catheter] to BSD [bedside drainage]. Dx [diagnosis] urinary retention. Monitor output X 3 days, then notify MD. F/C care q shift...." A Nurse's Note on 6/26/12 at 3:00 p.m., indicated the Foley catheter was anchored with 250 cc golden yellow urine immediately returned.			

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	A Nurse's Note on 6/29/12 at 2:30 p.m., indicated, "Outputs for past 3 days forwarded to [name of resident's physician's] office. Awaiting return call." Documentation in Nurse's Notes, Physician Progress Notes, and Physician's Telephone Orders failed to indicate the physician's response to the forwarded information. A Nurse's Note on 6/29/12 at 4:00 p.m., indicated the Nurse Practitioner visited, but the note did not indicate the information was provided to the Nurse Practitioner, or that a response to the forwarded information was provided. The Physician's Progress Note, dated 6/29/12, did not address the Foley catheter and the forwarded information about the urinary output. The Physician's Progress Note, dated 7/14/12, indicated, "S [subjective]: ...Has had Foley cath [catheter] in for 3 weeks. Wishes to have removed....A/P [Assessment/Plan] - ...Urinary retention - Trial remove Foley Monitor [symbol for with] prn [as needed] straight cath for retention." A Physician's Telephone Order, dated 7/14/12, included, but was not limited to,			

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	"...D/C [discontinue] Foley Monday 7/16/12. PRN straight cath q shift [every shift] (8 [symbol for hours]) prn. If has [sic] to do more than 3 Xs re-anchor Foley." This Federal tag relates to Complaint IN00112898. 3.1-5(a)(3)			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure care was planned related to a rash with itching (Resident B) and urinary retention (Resident F). The deficient practice affected 2 of 6 residents reviewed related to care planning in a sample of 6. Findings include: 1. The clinical record for Resident B was reviewed on 7/25/12 at 1:15 p.m. The Weekly Skin Assessment, dated	F0279	**F-279 It is the practice of this provider to use the results of the aassessments to develop, review and revise the residents comprehensive plan of care. The comprehensive plan of care includes measurable objectives and timetable to meet athe residents medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident	08/29/2012

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	7/9/12, indicated next to "Yes" for Discoloration/Rashes, "Rash to chest & R [right] [arrow pointing up - upper] arm." The assessment and nursing progress notes failed to indicate further assessment of the area. The Weekly Skin Assessment, dated 7/10/12, indicated a check mark "No" next to Discoloration/Rashes. The assessment was signed by the Director of Nursing. Nurses Notes, dated 7/15/12 at 1:15 p.m., indicated, "Resting abed - rashy area remains to [arrow pointing up - upper] rt [right arm] - scattered to rt shoulder - c/o [complains of] itching. [Symbol for no] other area noted." The Weekly Skin Assessment, dated 7/16/12, indicated next "Yes" for Discoloration/Rashes, "To [arrow pointing up] chest & [arrow pointing up] R [right] arm. Nurses Notes, dated 7/16/12 at 11:00 p.m., indicated, "Pt abed up ad lib [as desired]. Rash rt arm remain c/o itch. [Symbol for no] [sic] c/o." Nurses Notes, dated 7/17/12 at 2:15 a.m., indicated, "Resting abed. Red rashy area remains to [arrow pointing up - upper] rt		B care plan is in place relating to current skin condition. · Resident F's care plan has been reviewed and updated and reflects current condition. **How other residents having the potential to e affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Licensed nurses were in-serviced on developing plan of care for residents when completing a telephone order indicating a change of condition by the DNS/designee no later than 8/27//12. Post test included. · 100% audit of care plans were completed on or before 8/29/12 · Orders will be reviewed in clinical meeting to ensure care plan was completed as needed, · Non-compliance will result in further education including disciplinary action. · DNS/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the efficient practice does not recur?** · Licensed nurses were in-serviced on developing plan of care for residents when completing a telephone order indicating a change of condition by the DNS/designee no later than 8/27/12. Post test included. · 100% audit of care plans were completed on or before 8/29/12.	

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	arm & chest. C/o itching." Nurses Notes, dated 7/17/12 at 11:00 p.m., indicated, "resting abed up ad lib. Rash remain [arrow pointing up - upper] arm and chest. C/o itch area washed soap & H2O [water] pt states relief of itch @ this time." The Weekly Skin Assessment, dated 7/18/12, indicated next to "Yes" for Discoloration/Rashes, "Appears to be heat rash to BUE [bilateral upper extremities] & chest." A notation indicated, "This writer believes rash related to Res. [resident] wearing jacket out to smoke in hot temperatures." The assessment was signed by the Staff Development Coordinator. Nurse's Notes, dated 7/18/12 at 2:00 a.m., indicated, "Res abed watching TV....Rash remain to [arrow pointing up] R arm & chest. Cleansed area [symbol for with] soap & H2O, lotion applied for c/o itch." Documentation in the record failed to indicate the physician was notified of the resident's rash (noted on 7/9/12), followed by rash with itching (noted on 7/15/12), until the Nurse Practitioner visited on 7/20/12. The Physician's Progress Notes, dated		· Orders will be reviewed in clinical meeting by the DNS/designee to ensure care plan was completed as needed. · Non-compliance will result in further education including disciplinary action. · DNS/designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI audit tool for care plan updating will be utilized weekly x 4 weeks, monthly x 6 months and quarterly thereafter for any resident identified from new orders, 24hour report sheets, and documentation reviewed. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%	

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	7/20/12, indicated, "S [subjective]: Rash on chest & RUA [right upper arm] pruritic noticed by staff & pt. [patient] today. O [objective]: Confluent spotty pink dry papular rash A/P [assessment/plan] - Eczema -Betamethisone [sic] cream BID [twice daily]." The Physician Telephone Orders, dated 7/20/12, indicated, "Betamethasone cream 0.05% apply BID X 7d [seven days] dermatitis." The Care Plan Update section of the order was blank and failed to indicate a plan related to the care of the resident's rash with itching. The "At Risk for Impaired Skin Integrity Care Plan," originally dated 1/24/12, and most recently updated 6/26/12, failed to indicate a plan related to the resident's rash with itching. During interview on 7/26/12 at 2:30 p.m., the Director of Nursing indicated the care plan related to the resident's rash should be located in the Care Plan Update section of the Physician's Telephone Order. 2. The clinical record for Resident F was reviewed on 7/25/12 at 1:50 p.m. Nurse's Notes for 6/26/12, beginning at 8:30 a.m., indicated the resident			

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	complained of abdominal pain and feeling of fullness, followed by a 10:30 a.m. note that indicated the resident complained of nausea and increased abdominal distention. An as needed antiemetic was administered, and a call was placed to the physician. At 12:30 p.m., the resident continued to complain of abdominal discomfort, and a second call was placed to the physician. Nurse's Note on 6/26/12 at 12:40 p.m., indicated, "N/O's [new orders] rec'd [received] et [and] noted to anchor 16 Fr [french]. F/C care cc F/C [Foley catheter] to BSD [bedside drainage]. Dx [diagnosis] urinary retention. Monitor output X 3 days, then notify MD. F/C care q shift...." A Nurse's Note on 6/26/12 at 3:00 p.m., indicated the Foley catheter was anchored with 250 cc golden yellow urine immediately returned. A Nurse's Note on 6/29/12 at 2:30 p.m., indicated, "Outputs for past 3 days forwarded to [name of resident's physician's] office. Awaiting return call." Documentation in Nurse's Notes, Physician Progress Notes, and Physician's Telephone Orders failed to indicate the physician's response to the forwarded			

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HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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	information. A Nurse's Note on 6/29/12 at 4:00 p.m., indicated the Nurse Practitioner visited, but the note did not indicate a response to the forwarded information. The Physician's Progress Note, dated 6/29/12, did not address the Foley catheter and the forwarded information about the urinary output. The Physician's Progress Note, dated 7/14/12, indicated, "S [subjective]: ...Has had Foley cath [catheter] in for 3 weeks. Wishes to have removed....A/P [Assessment/Plan] - ...Urinary retention - Trial remove Foley Monitor [symbol for with] prn [as needed] straight cath for retention." A Physician's Telephone Order, dated 7/14/12, included, but was not limited to, "...D/C [discontinue] Foley Monday 7/16/12. PRN straight cath q shift [every shift] (8 [symbol for hours]) prn. If has to do more than 3 Xs re-anchor Foley." The Care Plan Update section of the Physician's Telephone Order form was blank. The resident's care plans were in a plastic sleeve in the clinical record. The care plans failed to indicate a plan related to			

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	ongoing assessment of the resident related to the discontinuation of the Foley catheter and ongoing monitoring for urinary retention. During interview on 7/25/12 at 4:16 p.m., RN #6 indicated Resident F lets staff know about her needs, including toileting needs. The nurse indicated the resident is assisted to toilet throughout the day, so staff know if she voids. During interview on 7/26/12 at 2:30 p.m., the Director of Nursing indicated there was no care plan related to monitoring Resident F for urinary retention. This federal tag relates to Complaint IN00112898. 3.1-35(a)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review, and interview, the facility failed to assess, obtain treatment orders, and/or provide care as planned related to skin care for 2 of 6 residents reviewed related to skin care needs. (Residents B and D) The facility also failed to clarify and/or provide care as planned related to swallowing needs for 1 of 1 resident reviewed related to swallowing and thickened liquids in the sample of 6 residents. (Resident D) Findings include: 1. A. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair with his breakfast tray within the resident's reach in front of him on his overbed table. Care for the resident by CNA #3 and LPN #4 was observed and was completed at 12:35 p.m. During care, the resident requested water, and LPN #4 indicated the resident was on thickened liquids. LPN #4 requested CNA #3 go to the dining room	F0309	F309 It is the practice of this provider to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being in accordance with the comprehencisve assessmetn and will be accomplished for those residents found to have been affected by the deficient practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D is receiving nectar thickened liquids only, no longer receives thin liquids and speech therapy has discharged resident related to hospice status. Resident is wearing Geri- sleeves at all times. The care plan and c.n.a. assignment sheet has also been updated to include current plan of care relating to thickened liquids and Geri- sleeves. Resident B's care plan and c.n.a. assignment sheet has been updated to include current plan of care relating to skin. How other residents having the potential to be affected by the same deficient practice will be identified and	08/29/2012

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	to obtain the fluids. LPN #4 indicated usually thickened water was in the refrigerator in the pantry, but Resident D does not like thickened water. She indicated the resident will drink the thickened juices available in the dining room. During care, LPN #4 indicated to the resident that she would wash his face to remove breakfast food debris from around the resident's mouth. During interview as CNA #3 prepared to remove Resident D's breakfast tray from the room, she indicated the liquids on the tray were a cup of thickened juice, two cups of thin water, one with a straw, and an insulated cup with lid, which contained thin water. On 7/25/12 at 4:05 p.m., CNA #5 was observed leaving Resident D's room. She indicated the resident was on thickened liquids, so she did not leave him any fluids at the bedside, since he could drink fluids on his own. She indicated the resident could have regular water between meals. She pulled her assignment sheet from her pocket, reviewed the sheet, and indicated information about the liquids was not on the sheet. She indicated the nurse had instructed her about the liquids. During interview after the CNA left, the resident indicated he wanted a drink of water.		what corrective action(s) will be taken? · All residents have the potential to be affected by the alleged deficient practice. · Licensed Nursing staff has been in-serviced on following physician's orders and plan of care by the DNS/designee no later than 8/27/12. Post test included. · CNA assignment sheets and care plans have been updated to ensure all interventions are in place. · All physician orders are reviewed daily by the DNS/designee. Physician orders are in place and are being followed. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · Licensed Nursing staff has been in-serviced on following physician's orders and plan of care by the DNS/designee no later than 08/27/12. Post test included. The charge nurse is responsible for ensuring care plan intervention and CNA assignment sheets are in place and will conduct rounds each shift. · All physician orders are reviewed daily by the DNS/designee with follow-up using the CQI minutes tool to ensure physician orders are in place and being followed.	

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	On 7/25/12 at 4:10 p.m., LPN #10 indicated the resident could have free water between meals, but not within 45 minutes of the meal. The clinical record for Resident D was reviewed on 7/25/12 at 2:25 p.m. The Speech Therapist Progress Note, dated 7/18/12, indicated the resident began receiving speech therapy services on 6/11/12, with focus on "Treatment of swallowing dysfunction and/or oral function for feeding." "Precautions" on the note indicated, "No thin liquids, unless on water protocol after proper oral care. Recommended liquids consistency is nectar thick liquids (NTL), straws ok." The significant change Minimum Data Set assessment, dated 5/21/12, indicated the resident had the swallowing disorder with signs and symptoms of "Loss of liquids/solids from mouth when eating or drinking." The Physician Telephone Order, dated 6/11/12, indicated, "ST [speech therapy] Clarification: Diet [symbol for change]: Continue regular texture, downgrade liquid consistency to nectar thick, straws ok. 2. ST to tx [treat] for dysphagia [difficulty swallowing] 5X/wk [week] for 4 wks [weeks]."		· Non-compliance with these practices will result in further education including disciplinary action. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The CQI audit tools for altered fluid consistency and skin management will be utilized monthly for 4 weeks, monthly for 6 months and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	The most recent Physician Telephone Order related to the resident's liquids was signed by the speech therapist on 7/12/12, and indicated, "Speech Therapy to continue swallowing therapy 3 X /week for 4 weeks, recertification period of 7/11/12 - 8/9/12. Effective date: 7/11/12. 2. Trials of thin liquids [symbol for with] SLP [Speech Language Pathologist] only." The Care Plan Update section of the Physician Telephone Order indicated, "Problem: dysphagia; Goal: 1. Least restrictive diet/liquid consist. [consistency] [symbol for with] min [minimal] S/S [signs and symptoms] aspiration. 2. Adequate hydration, remain pneumonia free. 3. Return to thin liquids when safe. Intervention: Skilled swallow tx [treatment], swallow strategies, education." The Occupational Therapist Progress Report and Updated Plan of Care, dated 7/12/12, indicated in "Current Level of Function" related to "Self Feeding - General," "The patient is able to feed self after set-up...." During interview on 7/26/12 at 11:45 a.m., the Medical Records Nurse indicated the most recent physician's order for the resident related to fluids was for nectar thick liquids and thin liquids			

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	with the speech therapist only. B. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair. The resident was wearing a short sleeved shirt, and visible on his arm was a white bandage to the left arm in the elbow area. During interview at this time, LPN #4 indicated the resident had a fall which resulted in a skin tear that morning, and LPN #4 and CNA #3 were observed transferring Resident D to bed. LPN #4 and CNA #3 assisted the resident with donning a clean shirt. The resident was not assisted to don geri-sleeves, and after care was completed at 12:35 p.m., the staff left the resident's room. On 7/25/12 at 4:05 p.m., Resident D was observed in his room in his low bed. He was not wearing geri-sleeves. On 7/26/12 at 11:45 a.m., Resident D was observed in his room in his low bed. He was not wearing geri-sleeves. On 7/26/12 at 1:30 p.m., Resident D was observed in his room in his low bed. He was not wearing geri-sleeves on his arms. The clinical record for Resident D was reviewed on 7/25/12 at 2:25 p.m.			

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	The most current physician's rewrite orders, signed 6/6/12, included, but were not limited to, "Geri-sleeves to bilateral arms." The Careplan Worksheet, originally dated 11/29/11, and most recently updated 5/29/12, indicated, "The resident is at risk for skin tears...." Interventions included, but were not limited to, "Geri-sleeves B [bilateral] arms at all times." The Treatment Administration Record (TAR) and Nurse's Notes for July 2012 did not indicate the resident refused the gerisleeves. The TAR indicated with a nurse's initials that the gerisleeves were on the bilateral arms on three shifts on 7/25/12 and on the 7:00 a.m. to 3:00 p.m. shift on 7/26/12. 2. On 7/25/12 at 4:00 p.m., LPN #2 was seated at the nurse's station charting. During interview, LPN #2 indicated Resident B had rash areas on his chest and arm, which the nurse thought might be heat-related, since the resident likes to wear long sleeves and a jacket, even in hot weather. Upon request, LPN #2 was observed assessing the skin on the right side of the chest and right upper arm of Resident B. The resident was observed to have a light red slightly splotchy area on the skin of the right upper chest and right			

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	upper arm. The clinical record for Resident B was reviewed on 7/25/12 at 1:15 p.m. The Weekly Skin Assessment, dated 7/9/12, indicated next to "Yes" for Discoloration/Rashes, "Rash to chest & R [right] [arrow pointing up - upper] arm." The assessment and nursing progress notes failed to indicate further assessment of the area. The Weekly Skin Assessment, dated 7/10/12, indicated a check mark "No" next to Discoloration/Rashes. The assessment was signed by the Director of Nursing. Nurses Notes, dated 7/15/12 at 1:15 p.m., indicated, "Resting abed - rashy area remains to [arrow pointing up - upper] rt [right arm] - scattered to rt shoulder - c/o [complains of] itching. [Symbol for no] other area noted." The Weekly Skin Assessment, dated 7/16/12, indicated next "Yes" for Discoloration/Rashes, "To [arrow pointing up] chest & [arrow pointing up] R [right] arm. Nurses Notes, dated 7/16/12 at 11:00 p.m., indicated, "Pt abed up ad lib [as			

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desired]. Rash rt arm remain c/o itch. [Symbol for no] [sic] c/o."

Nurses Notes, dated 7/17/12 at 2:15 a.m., indicated, "Resting abed. Red rashy area remains to [arrow pointing up - upper] rt arm & chest. C/o itching."

Nurses Notes, dated 7/17/12 at 11:00 p.m., indicated, "resting abed up ad lib. Rash remain [arrow pointing up - upper] arm and chest. C/o itch area washed soap & H2O [water] pt states relief of itch @ this time."

The Weekly Skin Assessment, dated 7/18/12, indicated next to "Yes" for Discoloration/Rashes, "Appears to be heat rash to BUE [bilateral upper extremities] & chest." A notation indicated, "This writer believes rash related to Res. [resident] wearing jacket out to smoke in hot temperatures." The assessment was signed by the Staff Development Coordinator.

Nurse's Notes, dated 7/18/12 at 2:00 a.m., indicated, "Res abed watching TV....Rash remain to [arrow pointing up] R arm & chest. Cleansed area [symbol for with] soap & H2O lotion applied for c/o itch."

The Physician's Progress Notes, dated 7/20/12, indicated, "S [subjective]: Rash

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	on chest & RUA [right upper arm] pruritic noticed by staff & pt. [patient] today. O [objective]: Confluent spotty pink dry papular rash A/P [assessment/plan] - Eczema -Betamethisone [sic] cream BID [twice daily]." The Physician Telephone Orders, dated 7/20/12, indicated, "Betamethasone cream 0.05% apply BID X 7d [seven days] dermatitis." The Care Plan Update section of the order failed to indicate a plan. During interview on 7/26/12 at 2:30 p.m., the Director of Nursing indicated skin sweeps are conducted monthly, and routine skin assessments are conducted weekly. She indicated she did skin sweeps and the Staff Development Coordinator did skin sweeps in July 2012. She indicated when she assessed Resident B, he had three little bumps at his wrist. She indicated, "On the 17th [sic] [name of the Staff Development Coordinator] went up to look at [the rash]." She indicated the care plan related to the resident's rash would be located in the Care Plan Update section of the Physician's Telephone Order. This Federal tag relates to Complaint IN00112898.			

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	3.1-37(a)			

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure residents received services to maintain comfort and personal hygiene for 2 of 4 residents observed receiving direct care in a sample of 6. (Residents A and D) Findings include: 1. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair next to his bed with his breakfast tray in front of him on his overbed table. The resident was leaning to the side with his head almost touching the arm rest of his wheel chair. A tray cart was observed outside the resident's room, and lunch trays were being delivered. The room was entered with LPN #4 and CNA #3. Upon entry to the room, the resident's face was observed to be soiled with food debris stuck around his mouth and onto his face. Resident D's pants were observed to have a large stain on the left side of the pants in the lap area. The stain included pieces of food. LPN #4 and CNA #3 transferred Resident D from chair to bed, LPN #4 used a wash	F0312	**F-312 It is the practice of this provider to provide the necessary services** to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D has clean clothing in his closet and is changed promptly when soiled, face and hands are cleaned after each meal, and resident is cleansed after each bowel movement using a washcloth or wipes. · Resident A's c.n.a. assignment sheet has been updated to reflect assistance needed for toileting. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Nursing staff will be in-serviced on personal hygiene on or before 8/27/12. Post test included. · Peri care skills check off will be completed for C.N.A's	08/29/2012

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	cloth, and indicated to the resident, "You got some of that breakfast on ya!" as she wiped around the resident's mouth. CNA #3 indicated the resident's brief was clean and dry. CNA #3 indicated the resident was also dry after breakfast when she checked him. As staff prepared to change the resident's clothing, including the stained pants, the closet and drawers of the room were observed to have no clean clothing in them. LPN #4 indicated the resident had moved to his room "yesterday," and she indicated apparently his clothing had not been moved to the new room, and would need to be obtained. The resident indicated he did not want to get back up to his chair for lunch, since he had been in his chair since breakfast. Care was completed at 12:35 p.m. The clinical record for Resident D was reviewed on 7/25/12 at 2:25 p.m. The significant change Minimum Data Set assessment,dated 5/21/12, indicated the resident scored 12 of 15 on the Brief Interview for Mental Status. The assessment indicated the resident required the extensive assistance of two staff for bed mobility and transfers, and the extensive assistance of one staff person for dressing and personal hygiene.		on or before 8/27/12. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Nursing staff will be in-serviced on personal hygiene on or before 8/27/12. Post test included. · Peri care skills check off will be completed for C.N.A.'s DNS/designee on or before 8/27/12. **The charge nurse will be responsible for conducting rounds to ensure resident personal hygiene and peri care is provided per plan of care.** · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI audit tools for accommodation of needs will be utilized monthly for 4 weeks, monthly for 6 months and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Care Plan Worksheet, originally dated 8/30/11, and most recently updated 5/29/12, indicated, the problem of, "The resident requires up to mod to max [moderate to maximum] assist in performing ADLs [activities of daily living] due to ...impaired transfers...impaired dressing...impaired personal hygiene...Parkinson's [disease], weakness." Interventions included, but were not limited to, "...Provide assist with ADLs as resident requires....Dress in clothes that are clean...." The Resident Care/Need Sheet (assignments for CNAs) for Resident D was provided on 7/30/12 at 8:45 a.m. The Special Needs listed for Resident D included, but were not limited to, "Keep towel in lap...offer to lay down if leaning in chair." 2. On 7/25/12 at 4:20 p.m., CNA #7 was observed assisting Resident A to the toilet. CNA #7 removed the resident's brief and indicated the brief was wet. The resident was assisted to transfer to the toilet. The resident had a bowel movement and was observed to use dry toilet paper to clean light brown stool from the anal/perianal area. CNA #7 used more dry toilet paper to clean light brown stool from the resident's anal/perianal area. The abdomen,		plan will be implemented for threshold below 95%. **Date of Compliance: 8/29/12**	

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	155203	A. BUILDING 00 B. WING	07/30/2012

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	perineal area, penis, and hips covered by the wet brief were not cleansed with wipes or wash cloths. The resident was assisted to don a clean pull-up. The clinical record for Resident A was reviewed on 7/26/12 at 9:45 a.m. The quarterly Minimum Data Set assessment, dated 6/18/12, indicated the resident was frequently incontinent of urine and occasionally incontinent of stool. The assessment indicated the resident required the extensive assistance of two staff for toilet use. The Resident Care/Need Sheet (assignments for CNAs) for Resident A was provided on the Initial Tour on 7/25/12 at 11:45 a.m. The assignment for Resident A indicated the resident used incontinent briefs and was to be offered toileting. During interview at the end of day conference on 7/26/12 at 5:00 p.m., the Administrator indicated she would expect a resident's skin to be cleansed with wipes or wash cloths after a wet brief was removed and the resident had a bowel movement. 3.1-38(a)(3)(A)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure interventions were planned for prevention of pressure ulcers to the heels, and implemented related to proper functioning of the resident's alternating pressure mattress for continued healing of pressure ulcers. The deficient practice affected 2 of 2 residents reviewed related to pressure ulcers in a sample of 6. (Residents D and E) Findings include: 1. During Initial Tour on 7/25/12, which began at 11:45 a.m., Resident D was observed in a Broda chair next to his bed. The room was entered with LPN #4 and CNA #3. Upon entry to the room, the resident was observed during transfer by LPN #4 and CNA #3 from chair to bed. During interview at this time, LPN #4 removed the resident's socks, felt the	F0314	**F-314** It is the practice of this provider to ensure that resident who enter the facility without pressure sores does not develop pressure sores unless the individual clinical condition demonstrates that they were unavoidable;and a resident having pressure sores receives necessary treatment and services to promote healling, prevent infection and prevent new sores from developing. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident D's heels are intact and has a Z- flow pressure relief cushion for heels. Resident's plan of care has been updated as well as the c.n.a. assignment sheet to include the heels up device. · Resident E's stage IV mattress was changed out and is working properly. **How other residents having the potential to be affected by the same deficient practice will be**	08/29/2012

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	heels on both feet, and indicated the heels were "a little soft." She indicated the heels were being treated with skin prep. When care was completed, the resident indicated he did not want to get back up to his chair for lunch, since he had been in his chair since breakfast. No pressure relief was provided for the resident's heels, and the heels were directly on the mattress when staff completed care at 12:35 p.m. On 7/25/12 at 4:05 p.m., Resident D was observed in bed. The resident's heels were directly on the mattress. The clinical record for Resident D was reviewed on 7/25/12 at 2:25 p.m. The Pressure Wound Risk Assessment, dated 5/21/12, indicated, "If the answer...is 'Yes', the resident is at risk for developing skin breakdown...." The resident's assessment indicated "Yes" to questions including, but not limited to, the following questions: "Does the resident slide down in bed or chair?" and "Does the resident have a history of pressure wounds?" The At Risk for Impaired Skin Integrity Care Plan, originally dated 2/28/12, and most recently updated 5/29/12, included no interventions specific to relieving		**identified and what corrective action(s) will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · Nursing staff will be in-serviced on or before 8/27/12 on skin management/devices. Post test included. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Nursing staff will be in-serviced on or before 8/27/12 on skin management/devices. Post test included. The charge nurse is responsible for making daily rounds to ensure devices are in place and treatments are completed as ordered. · Wound team will continue to make rounds on a weekly basis to ensure devices in place and treatments are completed as ordered and physicians are notified as changes are identified. · Non-compliance with this procedure and re-education will result in further training including disciplinary action · The Director of Nursing/designee will be responsible to ensure compliance. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur,**	

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	pressure on the resident's heels. Documentation on the physician rewrite and interim orders fur July 2012 failed to indicate the resident had a physician's order for skin prep to the heels during July 2012. During interview on 7/30/12 at 8:40 a.m., the Medical Records Nurse checked the resident's Treatment Administration Record and indicated the resident did not have an order for skin prep to the heels. During interview at the Exit Conference on 7/30/12, completed at 9:00 a.m., the Director of Nursing indicated she had added a Z-flow pressure relief cushion for the resident after the concern about the heels was brought to her attention. She also indicated the heels did not feel soft to her. 2. On 7/26/12 at 9:50 a.m., Resident E was observed in her room lying on an inflated specialty mattress. The control unit for the Stage IV 2000 Alternating Pressure Relief and Low Air Loss therapeutic mattress was attached at the foot of the bed, and the setting indicator panel on the unit was not lit up. The Social Services Director entered the room and observed the bed. He indicated he thought maybe the light on the setting indicator panel might time out and turn		**i.e., what quality assurance program will be put into place?** **· A CQI audit for specialty mattress and skin management will be completed weekly for 4 weeks, monthly for 6 months then quarterly thereafter.** · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	off after a period of time. Two of the resident's family members entered the room and indicated the lights on the setting indicator panel are always on. The Director of Nursing entered the room and indicated, "It's inflating - it's a Stage IV [type of bed]." The Social Services Director pushed the red switch on the side panel of the control unit, and the sound of blowing air started. During interview completed on 7/26/12 at 10:50 a.m., the technician from the specialty bed company supplying the Stage IV 2000 for Resident E indicated the control unit for the bed was not working properly, and he was changing the unit out. He indicated the mattress was inflated, but the alternating air portion of the mattress was not working properly. The technician indicated without the alternating part of the mattress functioning, the mattress was basically like any air mattress you have in the closet at home. The technician indicated he was replacing the control unit so the alternating function of the mattress would begin working. The clinical record for Resident E was reviewed on 7/26/12 at 11:50 a.m. The record indicated the resident was admitted 3/27/12 from the hospital, and subsequently hospitalized and readmitted			

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	on 4/2/12. The most recent Physician's Orders, dated for June 2012, and signed by the Nurse Practitioner on 6/11/12, included, but were not limited to, an order, originally dated 3/28/12, for "Resident to have low air mattress every shift R/T [related to] wounds." The Impaired Skin Integrity Care Plan, originally dated 4/2/12, and most recently updated 7/17/12, indicated interventions for the resident's pressure wounds including, but not limited to, "Pressure reducing/redistributing mattress on bed." The Pressure Wound Skin Evaluation Report indicated on 7/21/12, the resident had a Stage IV wound to the coccyx with length of 1.3 cm, width of 1.0 cm, and depth of 0.5 cm with tunneling at 11 o'clock of 1.3, at 10 o'clock of 1.1, and at 3 o'clock of 2.0. During interview on 7/26/12 at 1:15 p.m., RN #6 indicated Resident E had been scheduled for the first appointment at a wound clinic for evaluation of the wound on her coccyx on "last Friday [7/20/12]." She indicated the clinic had canceled the appointment and rescheduled for 7/27/12. During observation on 7/26/12 at 4:15			

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	p.m., LPN #8 was observed changing the dressing to the coccyx wound. During interview at this time, the resident indicated the wound hurt when the dressing was changed, and the resident was observed to wince as LPN #8 gently inserted and pushed normal saline soaked gauze into the wound. LPN #8 indicated the gauze packing strip was about 6 inches in length, and that the wound had not changed significantly since the resident was admitted to the facility. She indicated the wound never had much drainage 3.1-40(a)(2)			

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure a resident who required a Foley catheter for urinary retention had the catheter removed timely and that care was planned related to potential for urinary retention. The deficient practice affected 1 of 1 resident reviewed related to Foley catheters in a sample of 6. (Resident F) Findings include: The clinical record for Resident F was reviewed on 7/25/12 at 1:50 p.m. Nurse's Notes for 6/26/12, beginning at 8:30 a.m., indicated the resident complained of abdominal pain and feeling of fullness, followed by a 10:30 a.m. note that indicated the resident complained of nausea and increased abdominal distention. An as needed antiemetic was	F0315	F-315 It is the practice of this facility to ensure that a resident who enters the facility without an indwelling cathetar is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident F's Foley catheter has been discontinued. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? · All resident's have the potential to be affected by the alleged deficient practice. · Licensed nurses were in-serviced on Foley	08/29/2012

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	administered, and a call was placed to the physician. At 12:30 p.m., the resident continued to complain of abdominal discomfort, and a second call was placed to the physician. Nurse's Note on 6/26/12 at 12:40 p.m., indicated, "N/O's [new orders] rec'd [received] et [and] noted to anchor 16 Fr [french]. F/C care cc F/C [Foley catheter] to BSD [bedside drainage]. Dx [diagnosis] urinary retention. Monitor output X 3 days, then notify MD. F/C care q shift...." A Nurse's Note on 6/26/12 at 3:00 p.m., indicated the Foley catheter was anchored with 250 cc golden yellow urine immediately returned. A Nurse's Note on 6/29/12 at 2:30 p.m., indicated, "Outputs for past 3 days forwarded to [name of resident's physician's] office. Awaiting return call." Documentation in Nurse's Notes, Physician Progress Notes, and Physician's Telephone Orders failed to indicate the physician's response to the forwarded information. A Nurse's Note on 6/29/12 at 4:00 p.m., indicated the Nurse Practitioner visited, but the note did not indicate a response to		catheter policy/procedure and timely physician notification by the DNS/designee no later than 8/27/12. Post test included. · Non-compliance will result in further education including disciplinary action. · DNS/designee is responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the efficient practice does not recur? · All licensed nurse were in-serviced on Foley catheter policy/procedure and timely physician notification by the DNS/designee no later than 8/27/12. Post test included. · Residents with foley cathetar will be further reviewed by the DNS /Designee to ensure Physician orders are followed timely and careplan updated as needed. · Non-compliance will result in further education including disciplinary action. · DNS/designee responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The CQI audit tool for catheter assessment will be utilized weekly x 4 weeks and monthly for 6 months and quarterly thereafter for any resident identified from new orders, 24hour report sheets, and documentation reviewed. · Findings from the CQI process	

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	the forwarded information. The Physician's Progress Note, dated 6/29/12, did not address the Foley catheter and forwarded information. The Physician's Progress Note, dated 7/14/12, indicated, "S [subjective]: ...Has had Foley cath [catheter] in for 3 weeks. Wishes to have removed....A/P [Assessment/Plan] - ...Urinary retention - Trial remove Foley Monitor [symbol for with] prn [as needed] straight cath for retention." A Physician's Telephone Order, dated 7/14/12, included, but was not limited to, "...D/C [discontinue] Foley Monday 7/16/12. PRN straight cath q shift [every shift] (8 [symbol for hours]) prn. If has to do more than 3 Xs re-anchor Foley." The Care Plan Update section of the Physician's Telephone Order form was blank. The resident's care plans were in a plastic sleeve in the clinical record. The care plans failed to indicate a plan related to ongoing assessment of the resident related to the discontinuation of the Foley catheter and ongoing monitoring for urinary retention. During interview on 7/25/12 at 4:16 p.m.,		will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	RN #6 indicated Resident F lets staff know about her needs, including toileting needs. The nurse indicated the resident is assisted to toilet throughout the day, so they know if she voids. During interview on 7/26/12 at 2:30 p.m., the Director of Nursing indicated there was no care plan related to monitoring Resident F for urinary retention. 3.1-41(a)(1)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure effective interventions to alert staff to a resident's attempt to arise without assistance for falls prevention. The deficient practice affected 1 of 2 residents reviewed related to falls in a sample of 6. (Resident A) Findings include: During observation on 7/25/12 at 4:17 p.m., the sound of an alarm was heard from the hallway when nearing the open room door of Resident A. From the hallway, the resident was observed in bed, holding an alarm box in his hand. Blue mats were observed on both sides of the resident's bed. The resident's call light was behind the headboard of the bed out of his reach. The resident asked, "Do you hear that?" in regard to the alarm sound. The resident requested that the alarm be silenced. The resident indicated he needed to use the restroom. When encouraged to wait for the nurse to assist him as he tried to rise from bed, the	F0323	F323 What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: · Resident A's alarm was replaced, call light within reach at all times, and CNA assignment sheet/plan of care updated. ` · How will you identify other resident(s) having the potential to be affected by the same deficient practice and what corrective action will be taken: · All residents have the potential to be affected by the alleged deficient practice. · The nursing staff will be re-educated by the DNS/designee on or before 8/29/12 on the fall policy/procedures/interventions. Post test included. · The director of nursing services/designee is responsible to ensure compliance What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur: · The nursing staff will be re-educated by the DNS/designee on or before 8/27/12 on the fall policy/procedures/interventions. Post test included. · Audit was completed on all fall risk residents to ensure interventions were in	08/29/2012

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	resident indicated, "Call one of them." The resident questioned multiple times about the sounding alarm, which he continued to hold in his hand, and about getting help, and indicated, "I wish I could go [to the restroom] in my pants." At 4:20 p.m., CNA #7 was observed coming down the hall. As she neared the doorway of Resident A's room, she became aware of the sounding alarm, entered and silenced the alarm, and assisted the resident to the toilet. During interview at this time, CNA #7 showed how the resident's bed alarm was usually placed at the head of the bed above the pillow, with the clip behind the resident. The clinical record for Resident A was reviewed on 7/26/12 at 9:00 a.m. Nurse's Notes on 5/16/12 at 10:30 a.m., indicated, "...Res [resident] noted sitting on floor on buttocks in front of toilet....Res was asked what happened et [and] he stated, 'I went pee...." The Interdisciplinary Progress Notes, dated 5/17/12 at 10:00 a.m., indicated, "Resident had a fall on 5/16/12 @ 10:30 a.m. Fall was unwitnessed. Resident was sitting in wheel chair in hallway next to the medication cart. Resident got up to		place and functioning, current of their plan of care as well as the c.n.a. assignment sheet. · Alarms are checked daily for function and placement by the charge nurse through daily rounds. · Non-compliance will result in further education including disciplinary action. · The Director of Nursing/designee is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The CQI audit tool for fall management will be utilized weekly x 4 weeks, monthly x 6 months. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented for threshold below 95%.	

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	155203	A. BUILDING 00 B. WING	07/30/2012

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	take himself to the bathroom per resident. He was found sitting on buttocks on floor facing doorway in restroom with shoes on. Fall was in the restroom....Intervention started is a clip alarm. Resident has history of trying to stand and walk unassisted...." A Fall Circumstance Report, dated 7/11/12 at 5:45 p.m., indicated the resident experienced an unwitnessed fall in his room beside the bed. The response to question #13 indicated, "Res told this nurse, 'I was going to bed et [and] my leg gave out.'" The Care Plan, originally dated 4/11/12, and updated on 6/26/12 and 7/12/12, indicated the resident was at risk for falls. Approaches included, but were not limited to, "Call light in reach (4/11/12), low bed with mat on floor, bed in lowest position....Place clip alarm to wheel chair (5/16/12)....Offer to assist to bed [symbol for after] meals." The plan did not indicate use of the alarm in bed. During interview at the Daily Exit Conference on 7/27/12 at 5:00 p.m., the Director of Nursing indicated the battery in Resident A's alarm might need to be changed, since its sound is not very audible.			

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	3.1-45(a)(2)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure	F0441	F441 It is the practice of this provider to ensure that the	08/29/2012

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	staff followed infection control policies for handwashing and glove use during 1 of 4 observations of direct resident care for 6 sampled residents. (Resident B) Findings include: On 7/25/12 at 4:00 p.m., LPN #2 was seated at the nurse's station writing in charts. During interview, LPN #2 indicated Resident B had rash areas on his chest and arm, which he thought might be heat-related, since the resident likes to wear long sleeves and a jacket, even in hot weather. Upon request, LPN #2 was observed assessing the skin on the right side of the chest and right upper arm of Resident B. LPN #2 left the nurse's station to perform the assessment, and without washing his hands, using hand sanitizer, or applying gloves, he assisted the resident to adjust his clothing so areas on the right upper chest and right upper arm were visible. As LPN #2 was showing the areas, he touched the resident's chest and arm with ungloved hand. After the assessment, LPN #2 assisted the resident to readjust his clothing and left the room without washing the hands or using hand sanitizer. The clinical record for Resident B was reviewed on 7/25/12 at 1:25 p.m.		resident environment remains as free of accident as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident B was not affected by the alleged deficient practice and the rash is resolved How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? · All resident's have the potential to be affected by the alleged deficient practice. · Nursing staff has been in-serviced on washing hands and glove use by the DNS/designee on or before 8/27/12. Post test included. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? · Nursing staff has been in-serviced on washing hands and glove use by the DNS/designee on or before 8/27/12. Post test included. Handwashing skills checklist will be conducted for licensed staff by the	

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	The Physician's Progress Note, dated 7/20/12, indicated, "S [subjective]: Rash on chest and RUA [right upper arm] pruritic noticed by staff & pt [patient] today. O [objective]: Confluent spotty pink dry papular rash A/P [Assessment/Plan]: Eczema - Betamethasone [hydrocortisone for itching] cream BID [twice daily]." The Physician's Telephone Order, dated 7/20/12, indicated, "Betamethasone cream 0.05% apply BID X [times] 7d [days] Dermatitis." On 7/26/12 at 4:15 p.m., the Staff Development Coordinator (SDC) provided the Hand Hygiene Skills Check and indicated staff were expected to follow the check list when providing care. Review of the check list indicated, "Note: 5 moments of required hand hygiene: before patient [sic]...after patient contact...." On 7/26/12 at 4:50 p.m., the SDC provided page 4 of from what he indicated was the Infection Control Manual. Review of the document indicated, "Gloves: ...Wear gloves whenever touching resident's skin or surfaces close to resident...." The federal tag relates to Complaint		DNS/Designee to ensure understanding of Infection Control practices. · Non-compliance with these practices will result in further education including disciplinary action. · Director of nursing services/designee is responsible to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The CQI skills validation tool for hand washing and glove use will be utilized weekly x 4 weeks, monthly x 6 months and quarterly thereafter. · Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95% threshold.	

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